(6) Require the retention of financial and statistical records until it has audited the interim period and the settle-up rate;

(7) Make aggregate payments under this section for the interim period up to the level of the aggregate payments for the period immediately before to commencement of closure that is of the same duration as the interim period; and

(8) Change any other provision to which all parties to the plan agree.

D. As part of a phased plan, a nursing facility may receive a special rate adjustment The special rate adjustment may be received under more than one phase of the closure plan, and the cost savings from the closure of the nursing facility designated for closure may be applied as an offset to the subsequent costs of more than one phase of the plan. If a facility is proposed to receive a special rate adjustment or provide cost savings under more than one phase of the plan, the proposal must describe the special rate adjustments or cost savings in each phase of the plan.

(1) The special rate adjustment is effective no earlier than the first day of the month following completion of closure of all nursing facilities designated for closure under the closure plan.

(2) For purposes of a phased plan, the special rate adjustment for each phase is effective no earlier than the first day of the month following completion of closure of all nursing facilities designated for closure in that phase of the plan.

SECTION 20.027 **Planned closure rate adjustments under an approved closure plan.** Between August 1, 2001, and June 30, 2003, the Department may approve planned closures of up to 5,140 nursing facility beds, less the number of beds delicensed in facilities during the same period without approved closure plans or that have notified the Minnesota Department of Health of their intent to close without an approved closure plan.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure" means the cessation of operations of a facility and delicensure and decertification of all beds within the facility.

(2) "Closure plan" means a plan to close a facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities. A closure plan is submitted to the Department by a facility. Approval of a closure plan expires 18 months afer approval, unless commencement of closure has begun.

(3) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as part of an approved closure plan.

(4) "Completion of closure" means the date on which the final resident of a facility designated for closure in an approved closure plan is discharged.

(5) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

B. Closure rate adjustment calculation. The Department will calculate the planned closure rate adjustment according to the following:

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the facility or facilities receiving the planned closure rate adjustment are identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

C. A planned closure rate adjustment is effective on the first day of the month following completion of closure of a facility designated for closure in the application and becomes part of the facility's total operating payment rate.

D. A facility or facilities paid pursuant to this Attachment with a closure plan may assign a closure rate adjustment to another facility or facilities that are not closing or, in the case of partial closure, to the facility undertaking the partial closure. A facility may also elect to have a closure rate adjustment shared equally by the five nursing facilities with the lowest

total operating payment rates in the state development region in which the facility that is closing is located.

Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the Department, may assign a planned closure rate adjustment (including assigning the amount calculated under item B to themselves) if:

(1) they are delicensing no more than five beds, or less than six percent of their total licensed bed capacity, whichever is greater;

(2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and

(3) have not delicensed beds in the prior three months.

If a facility delicenses six or more beds, or six percent or more of its total licensed bed capacity, whichever is greater, and does not have an approved closure plan or is not eligible for the adjustment calculated in item B, the Department calculates the amount the facility would have been eligible to assign and uses this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region in which the facility that delicensed beds is located.

E. Applicants may use the planned closure rate adjustment to allow for:

(1) a property payment for a new facility;

(2) an addition to an existing facility; or

(3) as an operating payment rate adjustment.

F. A facility receiving a planned closure rate adjustment is eligible for any other rate adjustments under this Attachment.

G. A facility that receives a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to item B.

H. If the per bed dollar amount specified in item B, subitem (1) is increased, the Department will recalculate planned closure rate adjustments for facilities that delicense beds to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

I. Upon the request of a facility, the Department may delay the implementation of a closure rate adjustment to offset the cost of a non-Medicaid related facility closure rate adjustment approved by the Department pursuant to Minnesota Department of Health laws. This non-Medicaid related facility closure rate adjustment is a 50 percent rate increase to pay relocation costs or other costs related to facility closure.

SECTION 20.030 **Facility serving exclusively the physically handicapped.** Nursing facilities that serve physically handicapped individuals and which have an average length of stay of less than one year are limited to 140% of the other-operating-cost limit for hospital attached nursing facilities. Other facilities serving physically handicapped individuals but whose average length of stay is not less than one year have a limit of 105 percent of the appropriate hospital attached limit.

SECTION 20.035 **Hospital-attached nursing facilities.** A hospital-attached nursing facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program.

A hospital-attached nursing facility is a facility which meets the criteria in items A, B, or C.

A. A nursing facility recognized by the Medicare Program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-attached nursing facilities under the Medicare Program is a hospital-attached nursing facility.

B. A nursing facility which, prior to June 30, 1983, was classified as a hospital-attached nursing facility under Minnesota Rules, and which has applied for hospital-based nursing facility status under the Medicare program during the reporting year or the nine-month period following the nursing facility's reporting year, is considered a hospital-attached nursing facility for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application.

(1) The nursing facility must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's

recommended cost allocation methods had the Medicare Program's hospital-based nursing facility status been granted to the nursing facility.

(2) If the nursing facility is denied hospital-based nursing facility status under the Medicare Program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

C. The surviving nursing facility of a nonprofit or community operated hospital-attached nursing facility which suspended operation of the hospital is considered, at the option of the facility, a hospital-attached nursing facility for five subsequent rate years. In the fourth year the facility will receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility will receive 30 percent of the difference.

D. For rate years beginning on or after July 1, 1995, a nursing facility is considered a hospital-attached nursing facility for purposes of setting payment rates under this attachment if it meets the above requirements, and: (1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or (2) the nursing facility was recognized by the Medicare Program as hospital attached as of January 1, 1995 and this status has been maintained continuously.

SECTION 20.040 **Receivership.**

A. The Department in consultation with the Department of Health may establish a receivership fee that exceeds a nursing facility payment rate when the Commissioner of Health or the Commissioner of Human Services determines a nursing facility is subject to the receivership provisions. In establishing the receivership fee payment, the Commissioner must reduce the receiver's requested receivership fee by amounts that the Commissioner determines are included in the nursing facility's payment rate and that can be used to cover part or all of the receivership fee. Amounts that can be used to reduce the receivership fee shall be determined by reallocating facility staff or costs that were formerly paid by the nursing facility before the receivership and are no longer required to be paid. The amounts may include any efficiency incentive, allowance, and other amounts not specifically required to be paid for expenditures of the nursing facility. If the receivership fee cannot be covered by amounts in the nursing facility's payment rate, a receivership fee payment shall be set according to subitems (1) and (2) and payment shall be according to subitems (3) through (5).

(1) The receivership fee per diem is determined by dividing the annual receivership fee by the nursing facility's resident days from the most recent cost report for which the Department has established a payment rate or the estimated resident days in the projected receivership fee period.

(2) The receivership fee per diem shall be added to the nursing facility's payment rate.

(3) Notification of the payment rate increase must meet the requirements for the notice to private paying residents.

(4) The payment rate in item C for a nursing facility shall be effective the first day of the month following the receiver's compliance with the notice conditions.

(5) The Department may elect to make a lump sum payment of a portion of the receivership fee to the receiver or managing agent. In this case, the Department and the receiver or the managing agent shall agree to a repayment plan.

B. Upon receiving a recommendation from the Commissioner of Health for a review of rates, the Commissioner shall grant an adjustment to the nursing facility's payment rate. The Commissioner shall review the recommendation of the Commissioner of Health, together with the nursing facility's cost report to determine whether or not the deficiency or need can be corrected or met by reallocating nursing facility staff, costs, revenues, or other resources including any investments, efficiency incentives, or allowances. If the Commissioner determines that the deficiency cannot be corrected or the need cannot be met, the Commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the Commissioner's review by the nursing facility's actual resident days from the most recent desk-audited cost report.

C. If the Department has established a receivership fee per diem for a nursing facility in receivership under item A or a payment rate adjustment under item B, the Department must deduct these receivership payments according to subitems (1) to (3).

(1) The total receivership fee payments shall be the receivership per diem plus the payment rate adjustment multiplied by the number of resident days for the period of the receivership. If actual resident days for the receivership period are not made available within two weeks of the Department's written request, the Department shall compute the resident days

by prorating the facility's resident days based on the number of calendar days from each portion of the nursing facility's reporting years covered by the receivership period.

(2) The amount determined in item A must be divided by the nursing facility's resident days for the reporting year in which the receivership period ends.

(3) The per diem amount in item B shall be subtracted from the nursing facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends. This provision applies whether or not there is a sale or transfer of the nursing facility, unless the provision of item G apply.

D. The Commissioner of Health may request the Commissioner to reestablish the receivership fee payment when the original terms of the receivership fee payment have significantly changed with regard to the cost or duration of the receivership agreement. The Commissioner, in consultation with the Commissioner of Health, may reestablish the receivership fee payment when the Commissioner determines the cost or duration of the receivership agreement has significantly changed. The provisions of developing a receivership fee payment apply to the reestablishment process.

E. The Commissioner of Health shall recommend to the Commissioner a review of the rates for a nursing home or boarding care home that participates in the Medical Assistance Program that is in voluntary or involuntary receivership, and that has needs or deficiencies documented by the Department of Health. If the Commissioner of Health determines that a review of the rate is needed, the Commissioner shall provide the Commissioner of Human Services with: (1) a copy of the order or determination that cites the deficiency or need; and (2) the Commissioner's recommendation for additional staff and additional annual hours by type or employee and additional consultants, services, supplies, equipment, or repairs necessary to satisfy the need or deficiency.

F. Downsizing and Closing nursing facilities. If the nursing facility is subject to a downsizing to closure process during the period of receivership, the Commissioner may reestablish the nursing facility's payment rate. The payment rate shall be established based on the nursing facility's budgeted operating costs, the receivership property related costs, and the management fee costs for the receivership period divided by the facility's estimated resident days for the same period. The Commissioner of Health and the Commissioner shall make every effort to first facilitate the transfer of private paying residents to alternate service sites prior to the effective date of the payment rate. The cost limits and the case mix provisions in

the rate setting system shall not apply during the portion of the receivership period over which the nursing facility downsizes to closure.

G. Sale or transfer of a nursing facility in receivership after closure.

(1) Upon the subsequent sale or transfer of a nursing facility in receivership, the Commissioner must recover any amounts paid through payment rate adjustments under item F which exceed the normal cost of operating the nursing facility. Examples of costs in excess of the normal cost of operating the nursing facility include the managing agent's fee, directly identifiable costs of the managing agent, bonuses paid to employees for their continued employment during the downsizing to closure of the nursing facility, prereceivership expenditures paid by the receiver, additional professional services such as accountants, psychologists, and dietitians, and other similar costs incurred by the receiver to complete receivership. The buyer or transferee shall repay this amount to the Commissioner within 60 days after the Commissioner notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

(2) If a nursing facility with payment rates subject to item F, subitem (1) is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new owner's payment rates. Those payment rates shall continue to be in effect until the rate year following the reporting period ending on September 30 for the new owner. The reporting period shall, whenever possible, be at least five consecutive months. If the reporting period is less than five months but more than three months, the nursing facility's resident days for the last two months of the reporting period must be annualized over the reporting period for the purpose of computing the payment rate for the rate year following the reporting period.

Upon the subsequent sale or transfer of the nursing facility, the department may recover amounts paid through payment rate adjustments under this section. The buyer or transferee will repay this amount to the department within 60 days after the department notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

SECTION 20.050 **Medicare upper payment limit rate adjustment.** In the event that the aggregate payment rates determined under this plan exceed the Medicare upper payment limit established at 42 CFR § 447.272, a rate adjustment will be determined as follows:

A. Aggregate the payment rates determined under this plan.

B. Determine the Medicare upper payment limit in accordance with 42 CFR §447.272.

C. Subtract item A from item B.

D. If item C exceeds zero, divide the amount in item C by total statewide nursing facility resident days during the rate year in which item C exceeds zero.

E. Subtract item D from the rate otherwise determined under this plan.

SECTION 20.060 **Employee scholarship costs and training in English as a second language (ESL).**

A. For the rate years beginning July 1, 2001 and July 1, 2002, the Department will provide to each nursing facility reimbursed pursuant to Sections 1.000 to 21.000 or pursuant to Section 22.000 a scholarship per diem of .25 to the total operating payment rate to be used for employee scholarships and to provide job-related training in ESL.

B. For rate years beginning on or after July 1, 2003, the .25 scholarship per diem is removed from the total operating payment rate, and the scholarship per diem is based on actual costs.

SECTION 20.080 **Disproportionate share nursing facility payment adjustment.**

A. On May 31 of each year, the Department shall pay a disproportionate share nursing facility payment adjustment after noon on that day to a nursing home that, on that date, was county-owned and operated, with the county named as licensee by the Commissioner of Health, had over 40 beds and had medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility as of September 30, 1991. These payments are in addition to the total payment rate established under Section 18.000.

B. Beginning in 2002, in addition to the payment in item A, on May 31 the Department shall pay to a nursing facility described in item A a disproportionate share nursing facility payment adjustment in an amount equal to $29.55 per calendar day multiplied by the

number of beds licensed in the nursing facility on May 31. The provisions of item A apply.

C. Payments in items A and B are limited by the Medicare upper payment limits for non-state, government-owned or operated nursing facilities.

SECTION 20.090 **Disaster-related provisions.**

A. Notwithstanding a provision to the contrary, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal. Costs not paid in this manner may be claims on the subsequent cost report for inclusion in the facility's payment rate.

B. For transfers of less than 60 days, the rates continue to apply for evacuated facilities and residents are not counted as admissions to facilities that admit them. The resident days related to the placement of such residents who continued to be billed under an evacuated facility's provider number are not counted in the cost report submitted to calculate rates, and the additional expenditures are considered non-allowable costs for facilities that admit victims.

C. For transfers of 60 days or more, a formal discharge/admission process must be completed, so that the resident becomes a resident of the receiving facility.

D. When a person is admitted to a facility from the community, the resident assessment requirement in Section 15.010 is waived. If the resident has resided in the facility for 60 days or more, the facility must comply with Section 15.010 as soon as possible.

SECTION 20.100 **Bed layaway and delicensure.**

A. For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under Sections 1.000 through 21.000 that places beds on layaway will, for purposes of application of the downsizing incentive in Section 16.040, item G, and calculation of the rental per diem, have the beds given the same effect as if the beds had been delicensed so long as they remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Section 16.110. The property payment rate